

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-012961**

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3808

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

12009

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 22 DAYS	c. CITY OR TOWN DECATOR
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1865 EAST WOOD
3. NAME OF DECEASED (Type or print) First WYATT Middle C. Last ACKERMAN		4. DATE OF DEATH Month APRIL 2, Day 1963 Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/14/91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. MARINE		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
13a. FATHER'S NAME JAMES L ACKERMAN		14. NAME OF HUSBAND OR WIFE LILLIE B. ACKERMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW 2		17. INFORMANT LILLIE B. ACKERMAN SEE 2D	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE ARTERIOSCLEROTIC HEART DISEASE PNEUMONIA 177X		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from 3/11/63 to 4/2/63 Death occurred at 5:30 P on the date stated above, and to the best of my knowledge, from the causes stated.		and last saw him alive on 4/2/63	
22a. SIGNATURE William H. HOBACH M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 4/2/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-2-63	23c. NAME OF CEMETERY OR CREMATORY Greenville, Ill.	
24. FUNERAL DIRECTOR T. Dewey		25. DATE RECD. BY LOCAL REG. APR 3 1963	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by Not Embalmed, Student Embalmer No. \_\_\_\_\_,  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Kasey III

Licensed Embalmer No. ~~5039~~ 5039

P. O. Address E. St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.